FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING IL6010342 12/11/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2001 CEDAR STREET **DAYSTAR NURSING & REHAB CENTER** CAIRO, IL 62914 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Final Observations S9999 STATEMENT OF LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Illinois Department of Public Health

EVIDENCED BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

a) An owner, licensee, administrator, employee or

agent of a facility shall not abuse or neglect a

THESE REGULATIONS WERE NOT MET AS

Section 300.3240 Abuse and Neglect

resident. (Section 2-107 of the Act)

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING				
		IL6010342	B. WING		I .	C I1/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	- Marian		
DAYSTAR NURSING & REHAB CENTER 2001 CEDAR STREET CAIRO, IL 62914							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999		***************************************		
	interview, the facility transportation while for 2 of 2 residents transported in electrof 5. This failure reswheel chair while be van. As a result of the fractured left ankled. The findings include						
	Generalized Weakn Spinal Fusion of C3 December 2015 Phy sustained a fall from while being transpor	Id resident with diagnoses of less and Status Post Cervical -C7 as noted on the ysician Order Sheet. R3 in R3's electric power chair red to a doctor's appointment 00 am, as documented in the					
	that R3 and R5 were appointments on 12 transport van with E another vehicle that suddenly and withouturn. E2 stated that sbrakes to avoid a co of her wheel chair. E and assessed R3 ar under her. E2 stated comfort and drove in emergency room, wholocks from. E2 stated assistance from hos R3 back in her wheel to her originally schelars.	Aide, stated on 12-10-2015 be being transported to doctor -9-2015 in the facility 2 driving. E2 stated that was in front of her slowed at using its turn signal made a she had to suddenly apply allision causing R3 to fall out E2 pulled over immediately and noted that her left leg was I that she repositioned R3 for amediately to the hospital hich she was just a few ed that she obtained pital security personnel to get elchair. R3 requested to go on eduled doctor appointment, not injured. While at the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:					
		IL6010	342	B. WING			C 11/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AC	DRESS CITY	STATE ZIP CODE		
DAYSTAR NURSING & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2001 CEDAR STREET CAIRO, IL 62914							
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2		S9999			
	doctor appointment increasing pain in he recommendation of the facility, E2 took evaluation. E2 state a fracture of the left hospital.	R3 began exer left ankle at the doctor an R3 to the emed that R3 was	and at the nd after notifying tergency room for is diagnosed with				
	Review of R3's hos an admission date of had sustained fractifibula of the left ank recommended by the surgeon.	of 12-9-2015 ures of the di le with possil	verified that R3 stal tibia and ole surgery as				
	The facility Incident indicates that R3 sli being taken to a do had removed her set the power wheel ch transported in the v. 12-10-2015 at 1:35 chair when E2 had avoid another vehicle.	d out of her vector appointment belt which air. R5, who van at this time pm that R3 sto suddenly a	wheel chair while nent and that R3 is attached to was also being e, stated on lid out of her				
	On 12-10-2015 at 1 the facility transport present. E2 explains in a power wheelchar able to secure the puther estraint system belt portion and relie attached to the pow R3 usually always high that E2 does not rout that the seat belt is oriented. E2 stated sure that R3's belt was loaded into the	van was obsed that when air is secured ower chair to but is unable as on the sea er wheel chairs her seat butinely check buckled since that she could as fastened	a resident that is in the van, E2 is the floor with to use the seat to belt that is ir. E2 stated that telt buckled and to make sure R3 is alert and d not state for				

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STATE FORM DYU411 If continuation sheet 3 of 5

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7332723101	DENTIS TOATION NOWDER.	A. BUILDING	Management of the second of th	COMP	LEIED
	IL6010342	B. WING		ł	0
NAME OF DEOVIDED OD SUDDIUM		1		1 12/1	11/2015
NAME OF PROVIDER OR SUPPLIER	2004 CED	DRESS, CITY, DAR STREE	STATE, ZIP CODE		
DAYSTAR NURSING & REHAB CEN	ITER CAIRO, IL		•		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCED)	D BE	(X5) COMPLETE DATE
An owners manual, with for R3's power wheel chawww.pridemobility.com. recommendations state of Vehicle Transport" that it "you do not remain seate while traveling in a motor following warning "Do nowhile in a moving vehicle "Positioning Belt" it states not designed for use as a The American Occupation published an article in the Practice regarding safe to chair users, the article is (1999) Guidelines for Safe Chair Users." It is stated in this article the positioning aides do not constraints and that a wheet transport someone (in a equipped with an automothat fits snuggly over the pelvis It further states to down were used without a system the person would the belts and restraints at chair. The article concludiuse of equipment can lead that facilities should deverguidelines (for wheel chair E1, Administrator, stated that there was no facility paddress the use of the resund that the van was purcome with any manufacture was no manufacture.	air was located on line at The manufacturer on page 13 under "Motor is recommended that ad in your power chair vehicle" and has the t sit on your power chair to page 26 under to page 27 page 28 page 29 p	S9999			

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